

## **Durable Medical Equipment (DME) Fraud and Abuse**

### ***What is durable medical equipment (DME)?***

Durable Medical Equipment (DME) is medically necessary, prescribed by a doctor, can withstand repeated use, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

### ***Why look at durable medical equipment?***

- There is a huge potential for quick profit.
- Suppliers find it relatively easy to obtain beneficiaries' Medicare Health Insurance Claim Numbers.
- There are no professional licensing requirements for DME suppliers or oversight by the Health Services Permit Commission (HSPC), the Arkansas Department of Health (ADH) or the Department of Human Services (DHS). DME providers only need a standard business license and supplier number.
- In the past, Medicare contractors have not verified the existence or location of the suppliers.

### ***Medical Necessity Issues:***

- Suppliers are required to fill out Certificates of Medical Necessity (CMNs) that describe products and equipment to be used by the patient. The provider may not complete the medical information section of the CMN. Only a doctor can fill out this section.
- The CMN forms suggest Medicare allowable charges and equipment options that can be selected to meet the patient's needs by the prescribing physician.
- CMNs must be signed by the attending doctor to certify medical necessity.

- Once “medical necessity” has been established and documented by the beneficiary’s doctor, the Durable Medical Equipment Regional Carrier (DMERC) may purchase certain items or make monthly payments to suppliers for rented DME. When the patient no longer needs the equipment, the supplier is not entitled to any additional monthly payments. Beneficiaries should notify their supplier to pick up unused equipment and request a pick-up slip.

### ***Assignment Violations:***

In the Original Medicare Plan, participating physicians or suppliers agree to accept assignment (the Medicare approved amount for Medicare covered services) as payment in full. These doctors or suppliers may bill you **only** for the Medicare deductible and/or coinsurance amounts.

For most services, Medicare will pay 80% of the approved amount to the doctor or supplier. You would then owe the remaining 20%. Your supplier of medical equipment should always submit the claim to Medicare for you.

Many doctors and suppliers have signed “participating agreements” with Medicare, which are renewable each year, to **ALWAYS** accept Medicare’s allowed fees as payment in full.

*REFER to Medicare’s participating provider handbook for a listing of participating suppliers near you. You may also check with your local DHS Office or with the Office of Aging and Adult Services.*

### ***Fraud schemes:***

- Unscrupulous suppliers use a variety of means to obtain Medicare Health Insurance Claim Numbers, knowing that having a supply of these numbers is an open door to obtaining Medicare dollars fraudulently. Their methods include:
  - ✓ Paying beneficiaries for their Medicare number.
  - ✓ Offering beneficiaries "free" services or supplies (e.g., milk, bread, clothing, etc.) in exchange for their Medicare number.

- ✓ Calling beneficiaries under the guise of conducting a "health survey." One of the questions is, "What is your Medicare number?"
- ✓ Offering beneficiaries a free "health screening" (e.g., blood pressure check, cholesterol test, etc.) and asking, "What is your Medicare number?"
- ✓ Obtaining lists of Medicare beneficiaries and their Medicare numbers from nursing homes or other long-term care facilities by selling the operator/administrators on "new" Medicare benefits that will help their facility.
- Recruiters or "**Cappers**" offer money to beneficiaries to visit a clinic for "free" medical screening tests. The beneficiary gets a quickie examination and a laundry list of DME equipment that the beneficiary doesn't need.

**For example**, a DME company recruited and transported patients to the office of a doctor, who wrote or signed a prescription for them. Then they would take the patients to their place of business and let them select various medically unnecessary items from their store at no cost, including mixers, sheets, comforters, coffee makers, metal canes, and low-end non-custom fitted or non-custom molded elastic braces. They billed Medicare for custom fitted or custom molded orthotics (supports, braces) and incontinence supplies.

- **SCOOTER FRAUD.** Power wheelchair providers may use unscrupulous tactics to create a need for these products. They advertise, "free to the patient" or "Medicare may provide for you." Medicare is often billed for a power wheelchair when a less expensive scooter is actually provided.

**For example**, a DME company solicited Medicare and Medicaid beneficiaries in order to sell them motorized scooters. After securing the sales, they billed federal health care programs and a private insurer for motorized wheelchairs, which cost about twice as much as scooters that were provided.

- Hospitals have allowed DME companies to provide them with "discharge planners." These employees work in the hospital but are employed and paid by the DME supplier. They make sure that

patients receive every item imaginable (e.g., hospital beds, wheelchairs, walkers, etc.), whether they need them or not.

- Doctors order unnecessary equipment and/or supplies that the beneficiary does not need. Many times, the equipment goes untouched. The beneficiary does not know what the equipment is for or how to use it, and sticks it in the closet.
- Suppliers do not pick up equipment that is no longer needed, even after they have been called several times by the beneficiary, because they can continue to bill for equipment as long as they don't pick it up. Sometimes they continue to bill for the equipment even after it has been picked up.
- **Surgical dressing scams. Examples are:** repetitive delivery of dressings on a schedule, regardless of medical need; billing for dressings that are contraindicated; and provision of wound coverings not proportional to the size of a wound or the number of wounds.
- Adult diapers, which are not covered by Medicare, have been billed as Female Urinary Collection Devices (FUCDs), which are covered for patients who have permanent urinary incontinence, when used as an alternative to an indwelling catheter. Suppliers may misrepresent the item and the patient's condition on the bill. Then Medicare pays nearly \$9 per FUCD when diapers that cost the supplier 26 cents each are provided to the patient. Incontinence charges to Medicare have been as high as \$5,200 per month per patient.
- Obstructive Sleep Apnea (OSA)<sup>1</sup> can be treated with either a Continuous Positive Airway Pressure (CPAP)<sup>2</sup> machine or a more expensive Bilevel Positive Airway Pressure (BiPAP)<sup>3</sup> machine. A

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<sup>1</sup> Recurrent episodes during sleep when closure of the throat due to muscle relaxation prevents passage of air into the lungs for 10 seconds or more. OSA episodes can last as long as 2 minutes and are almost always associated with reduction in the blood oxygen level. Waking up terminates the apnea and saves the victim's life.

<sup>2</sup> This machine delivers continuous air pressure for all breaths.

<sup>3</sup> With a BiPAP machine, the pressure varies during each breath cycle. When the user inhales, the pressure is similar to CPAP. When they exhale, the pressure drops, making it much easier to breathe. These machines are commonly prescribed for patients who have difficulty tolerating CPAP.

CPAP unit may be supplied and Medicare is billed for a BiPAP unit in order to increase reimbursement.

- Medicare has been billed for Nebulizer<sup>4</sup> drugs, which are used to relieve symptoms of chronic lung diseases [asthma, emphysema, bronchitis, COPD (chronic obstructive pulmonary disease), lung cancer and cystic fibrosis]. Claims review showed inappropriate quantities and combinations were billed. In fact, some suppliers were not even providing the drugs billed to Medicare.
- Vendors offer "free" cases of milk supplements or groceries, then bill Medicare for costly enteral/parenteral supplies.
- Lymphedema<sup>5</sup> pumps are supplied to beneficiaries who did not meet the medical necessity requirements.<sup>6</sup> Suppliers falsified the MSNs and Certificates of Medical Necessity (CMNs). Medicare was billed for higher-priced pumps, some costing nearly \$3,000.
- Some suppliers have ownership in or arrangements with physiological laboratories that falsify oximetry tests<sup>7</sup> in order to certify patients' need for home oxygen.
- Medicare pays for oxygen concentrators for patients who need oxygen. Because Medicare requires patients to be tested by an independent laboratory before paying for oxygen, suppliers have engaged in schemes with physicians and labs to falsify oximetry results.

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<sup>4</sup> A device, with a face mask attached, for administering a medicinal liquid in the form of a fine spray that is breathed in through the mouth or nose

<sup>5</sup> Lymphedema is an accumulation of lymphatic fluid that causes swelling of the arms, legs, breast, neck or head following surgical removal of lymph nodes. Breast cancer surgery is the most common cause of the condition in the United States.

<sup>6</sup> Medicare will cover the pump after the beneficiary undergoes an initial 4-week therapy of conservative care (elevation, exercise and the use of a compression garment) that fails to control the problem.

<sup>7</sup> Pulse oximetry is a simple non-invasive method of monitoring the percentage of hemoglobin (Hb) that is saturated with oxygen.

- Using another person's Medicare card to get medical care, supplies, or equipment

### ***Things to look for:***

- Services not provided
- **UPCODING** – billing for a more expensive or Medicare covered item when a less expensive, non-covered item was provided
- Submitting duplicate claims for the same service
- **KICKBACKS** to doctors for patient referrals
- Certificate of Medical Necessity (CMN) Violations
- Fraudulent attempts to obtain Medicare Health Insurance Claim Numbers through telemarketing, health screenings, medical surveys, or offers of "free" items or cash.
- In long-term care facilities, look for DME items that have been provided to all or most residents (**for example**, all patients in a nursing home have air fluidized beds).<sup>8</sup>
- Does it appear that the consumer required the supplies or equipment received?
- Did the supplier waive co-pays and deductibles in the absence of financial need?
- Review Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to ensure that the equipment and supplies billed match the services that were provided.

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<sup>8</sup> A specialized bed that employs the circulation of filtered air through ceramic spherules (small, round ceramic objects) that is intended to treat or prevent bedsores, to treat severe or extensive burns, or to aid circulation. Medicare covers the cost, after all other alternative equipment has been ruled out, when the patient has a stage 3 or 4 pressure sore or is bedridden or chair bound due to severely limited mobility. A physician must prescribe the bed and re-evaluates and re-certify the need on a monthly basis.

- When the use of rented DME stops, beneficiaries should notify their supplier to pick up the equipment and any unused supplies and request a pick-up slip. EOMBs or MSNs should then be checked to ensure that the monthly payments have stopped.

### ***Commonly misrepresented products:***

- A power wheelchair was billed to Medicare and a three-wheel scooter was provided.
- An inexpensive adjustable lower back support was misrepresented on the bill as a custom fitted or custom molded body jacket.
- A non-coded hip guard product was provided and Medicare was billed for a custom fitted post-operative Hip orthosis (brace).
- An inexpensive seating cushion was provided and Medicare was billed for a much more expensive alternating pressure pad.
- Diapers were provided to nursing home residents and Medicare was billed for urinary collection devices.
- Wrist-Hand-Finger-Orthotics (WHFOs) were upcoded to more medically sophisticated orthotics (supports, braces).
- A CPAP unit was provided to the patient and a more expensive BiPAP machine was billed to Medicare.

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

**To Report Suspected Medicare or Medicaid Fraud**  
**Call Toll-free 1-866-726-2916**  
**Or write to address below**